Minutes of the Managed Risk Medical Insurance Board's (MRMIB's)
Mental Health (MH) Liaison Workgroup Meeting
Thursday, April 23, 2009
10am-12pm

HFP Plan and Behavioral Health Plan Representatives:
Blue Cross of California – Terry Maxson
Blue Shield of California - Brenda Kaplan, Joan Peet
CalOptima - Gisela Gomez, Michelle Datwyler
Community Health Group – George Scolari
Community Health Plan – Edwin Penate
Health Net – Rogelio Lopez
Inland Empire Health Plan – Gary Melton, Dr. Peter Currie
Kaiser Permanente – Dr. Stuart Buttlaire, Kathy Lurty, Carla Hix
Kern Health Systems - Anne Watkins, Julia Davis
Molina – Michele Marcotte, Katherine Davidson
Optumhealth – Jennifer Patterson, Martine Taynor
Ventura County Health Care Plan – Joan Araujo

County Mental Health Directors Association
Don Kingdon
Suzanne Tavano

Department of Mental Health
Caroline Castaneda
Heidi Lange

County Mental Health Representatives:
Calaveras County – Denise Giblin
Fresno County – Trevor Birkholz
Sacramento County - Billie Willson
Stanislaus County – Donna Trio
Yolo County –

APS Healthcare
Esperanza Calderon
Sandra Sinz

Other
Cassie Willis – Psychiatric Centers in San Diego

MRMIB Staff:
Shelley Rouillard – Deputy Director, BQM Division

Ruth Jacobs – Assistant Deputy Director, BQM Division
Sarah Swaney - Research Program Specialist, BQM Division
Juanita Vaca – Research Analyst, BQM Division

Welcome and Introductions

Juanita Vaca introduced in-house participants and welcomed everyone. Participants were asked if there were any changes to the agenda.

CHIPRA

Shelley Rouillard gave an overview on Children's Health Insurance Program Reauthorization Act known as CHIPRA that President Obama signed in February. Provisions of the bill take effect April 1, 2009, unless a different effective date is included in the bill. Key points of CHIPRA are:

- Application of the Deficit Reduction Act (DRA) citizenship requirements that are required in Medicaid (MC) will now be applicable in HFP. Effective 1/1/10, if state law needed then 1/1/11.
- Mental health and substance abuse parity is broader than what California currently has and would include all mental health conditions, not just the ones listed in the statute. Can not have service limitations or different co-pays. MRMIB will have to make changes to the benefits structure which will require a state law change and would be implemented 1/1/11.
- State cannot prevent a Federally Qualified Health Center (FQHC) from contacting with a private dentist. This applies to MC and CHIP. Effective 4/1/09.
- Dental coverage required. HFP provides dental benefits; this should not affect us unless CMS determines that orthodontia needs to be a covered benefit. In HFP if a child has a severe need for braces they can get them through CCS, if eligible. May need an encounter and claims system to be able to report to CMS about dental access.
- FQHC's and Rural Health Centers (RHC) must be paid as they are in MC. If plans contract with these clinics for a certain amount but that amount is less than what the clinic costs are, MRMIB will have to pay the difference in much the same way that MC currently does when the clinics are contracted in the Medicaid Managed Care (MMC) program. State law change, effective 1/1/11.
- Certain MMC standards that related to enrollee protections, anti-discrimination, conflict of interest are now going to apply to CHIP. MRMIB is doing an analysis of what this actually may mean to HFP. This may require MRMIB to have an encounter and claims system which we were developing but was stalled due to the Confidentiality of Medical Information Act. Will wait for guidance from CMS. Effective 7/1/09 unless state law change needed then it would be 1/1/11.
- There is now going to be a national focus on quality in CHIP. There will be some quality initiatives starting at the federal level through the Secretary of Health and Human Services (HHS) to establish a core set of quality measures that all states will

report. The Institute of Medicine (IOM) and the Government Accountability Office (GAO) will be assessing indicators for future modification. The IOM will do the first report on what measures the states are currently using to make recommendations to the Secretary of HHS. After one year of implementation there will be modifications to what MRMIB would have to submit for the first child health quality report to CMS in 2011. Effective 1/1/10.

- States do have the option to cover children up to 300% of poverty level at current CHIP funding (65%/35%). If states want to go above the 300%, the reimbursement rate will be made at the MC funding ratio, which is lower. If California wants to expand coverage it would then have to submit a State Plan Amendment by August 31, 2009 to be effective federal fiscal year 2010. Effective 4/1/09.
- States also have the option to cover pregnant women with CHIP funds. California currently covers through AIM using federal matching funds through the Unborn Child Provision, which covers the woman because the unborn child she is carrying is the covered member. Effective 4/1/09.
- Draw down Federal Financial Participation (FFP) for recent legal immigrant children and pregnant in both MC and CHIP. States must obtain verification during eligibility predetermination in the U.S. The five year ban no longer in affect. Effective 4/1/09.
- Express lane option to use findings from school lunch, Women, Infants and Children (WIC) and other public agencies when determining eligibility for MC and CHIP. Effective 2/4/09.
- States may provide dental supplemental coverage for children who have health coverage through their parents but do not have dental coverage. There are a number of requirements the state would have to adhere to in order to implement this option. MRMIB will be looking at this later in the fall as to do an assessment of the feasibility. Effective 4/1/09, if state law change needed, effective 1/1/11.
- Option to use SSN match to meet citizenship documentation requirement. Effective 4/1/09.
- Purchasing pool for employers with fewer than 250 employees. One employee must be pregnant or have an eligible child. No CHIP funds can be used on the administration of the pool. This sounds like it would be state funded and would require state statute. Effective 4/1/09.
- Fund school based health centers with CHIP funds. This is a state option and California does not do this. Effective 4/1/09.
- Premium assistance in both CHIP and MC. Employer must contribute 40% of cost. Effective 4/1/09, but requires state statute, so would not be implemented until 1/1/11.
- Performance bonus for increased MC enrollment of uninsured children. 5 simplified enrollment rules that states need to meet to be eligible for the performance bonus. This applies to MC not HFP. Effective 4/1/09.
- Outreach funding geared to rural areas and racial and ethnic populations. CMS to allocate these funds to states. Effective 4/1/09.
- States to get increased Federal Medical Assistance Program (FMAP) for translation and interpretation services in both MC and CHIP.

- GAO will be doing a report on Medicare Managed Care (MMC) rates and any issues related to access as a result of what those rates may be. Report due in August 2010.
- New commission on payment and access in MC and CHIP. Reports due out in March and June 2010.
- Small employer education and outreach task force. No information on this.
- Payment Error Rate Measurement (PERM) has some final rules within the next six months on what they expect from states with reporting payment error rates.

Shelley informed the workgroup the CHIPRA summary document was on the MRMIB website. The website is the method for the workgroup to stay apprised of all that is going on with CHIPRA.

SED Report

Sarah Swaney gave an overview of the findings from the Mental Health Utilization Report presented at the April 22nd Board meeting. This report is for benefit years 2004/05, 2005/06, 2006/07 and did not include Substance Abuse (SA) utilization. Approximately 1% of non-Kaiser HFP children were treated by counties for SED. This has been consistent and translates to an average of about 7400 children annually. More than half of children receiving SED treatment are teens between ages 13-18, three quarters of children receiving mental health treatment are ages 10 and over.

The average cost per case (data from DMH) increased 33% in 2007 from $2600 in 2000. Approximately three quarters of county expenditures for HFP children with SED are for mental health services that include assessment, evaluations, therapy, and rehabilitation services. MRMIB does not have data on the cost of prescription drugs to treat children with SED; because counties cannot claim for prescription drugs and so do not report the costs.

On plan referrals over the three year period about one quarter of 1% of HFP children were referred to the county mental health department for assessment and treatment of SED. There is no change in what was reported in the prior Mental Health Utilization report of 2006. Plans referred 60-70% of HFP children, while other sources such as schools, juvenile system, and family members made the remaining 30-40% of referrals. The percent of SED referrals accepted by the counties has been declining in 2006/07. Approximately 63% of all HFP children referred for SED were accepted by the counties mental health department for treatment compared to 72% in 2004/05 and approximately 9% of referrals were refused by families. This is an overall aggregate for all plans. Newly gathered information shows that some families did not want to receive services from the counties. The data on this topic had not previously been gathered.

For basic mental health services for the three years covering this report, approximately 3% of HFP members received plan provided mental health services. Only 2% of non-Kaiser enrolled received mental health services through their health plan. In each benefit year Kaiser reports the highest percentage of HFP members receiving plan provided mental health services. Kaiser's rate of providing these services to HFP members has risen from 7% in 2004/05 to 10% in 2006/07.

Sarah informed the workgroup the Mental Health Utilization report that includes graphs and charts could be found on the MRMIB website.

Shelley Rouillard stated that MRMIB is trying to ascertain prevalence of the need for mental health services in the general child population. Reports on the web talk about 9% of children would be expected to receive services for SED treatment and about same percentage for Serious Mental Illnesses (SMI). The serious concern is lack of mental health services being provided when needed. This is a challenge for the counties with declining revenues.

Don Kingdon of CMHDA would like to factor in children receiving services similar to the SED benefit under AB3632 which is the bill regarding the Special Education Eligibility. Many counties do not cross claims or submit claims to HFP when serving children under that eligibility category. Don was asked if this data could be obtained. Don stated that they could cross verify through names or social security numbers which may not be appropriate. CMHDA would like to work with MRMIB to figure out a mechanism to capture the data because utilization rates are lower than we would want them.

Suzanne Tavano added that a good percentage of children who are seen by the counties under the SED benefit do not all come through a referral from the plan but are rather identified in the system as a "high need child". These come directly into care with the county and she doesn't know if this data is accounted for. The basic referral rate is low, ¼ of 1% were referred to the county mental health department and the counties have wondered how these children are identified by the health plans.

Shelley reiterated that one of the findings in the report depending on the benefit year was that 30-40% of children are referred by other sources.

Ruth Jacobs stated that the APS contract will help MRMIB find out what assessment tools the plans are using. In many cases a standard assessment is being used and not just for HFP. We will have to see what APS finds while doing the study. When MRMIB starts collecting encounter and claims data we will also get a better sense of what plans are doing.

APS Update

Esperanza Calderon of APS is working on collecting policy and procedure documents requested early in the year. APS has sent out the data request for source of data that would be viable to collect. Have been working on final request documents:

- HFP Enrollment and Demographic
- Mental Health Inpatient and Outpatient Services
- Substance Abuse Inpatient and Outpatient Services
- Pharmacy

The focus groups will be January/February. Visiting the counties will begin in the fall. APS has graduate students working on the documents submitted by the plans, such as assessment sheets, intake forms etc. Questions plans are asked will be integrated in the focus groups, although APS will also get an oral history on what's going on. This will give a better idea of what is happening.

Michele Datwyler of CalOptima asked if the plans working with APS will get an updated timeline. Esperanza advised that she was working on it.

George Scolari asked Esperanza what APS is looking at when it comes to intake of substance abuse (SA).

Esperanza provided the workgroup with a summary of what is being requested:

- Number of members receiving SA services
- Number of days receiving services
- Number inpatient days having clinicians provide services
- Number of non-SED members who were inpatient more than 30 days
- Number of co-occurring disorders, members who were hospitalized for MH and SA diagnosis
- Number of members who had one SA inpatient admission, 2-4 admissions, more than 5 admissions
- Number of members who had at least 1 admission during the benefit year and of those total number of members receiving outpatient care during the benefit year
- Number of members having a least 1 inpatient admission and receiving subsequent outpatient care
- Number of days from hospital discharge to first outpatient visit

George Scolari said the HFP benefits structure does not talk about the inpatient SA treatment.

Esperanza Calderon said some plans may be doing more than what the regulations state. The plans were told that if questions do not pertain to them then the plan can note that information on the data request form. This will be a way to note what other things the plans are doing that are not being accounted for.

SED Brochure

Juanita Vaca asked the workgroup if they had looked over the SED brochure draft and what their feedback was on it.

George Scolari said get it finalized to start using it and said that folks in the San Diego Department of Mental Health liked it as well.

The SED brochure will be translated into the top five languages of HFP.

The workgroup was advised that comments on the brochure had to be submitted by April 30th.

OPEN FORUM

Suzanne Tavano said the "referral form" has been discussed over the years and it should be looked at again. The counties would like to see this formalized.

NEXT MEETING:

Next meeting will be July 30, 2009.

Meeting was adjourned.